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Statement
of the
American Hospital Association
before the
Committee on Commerce
Subcommittee on Health and the Environment
of the United States House of Representatives
on
Provider-Sponsored Organizations

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Mr. Chairman, I am John C. McMeekin, President and CEO of Crozer-Keystone Health System in Media, Pennsylvania, just outside of Philadelphia. We are a comprehensive health system, offering health promotion services, primary and specialty physician care, hospital services, and home health, long-term and hospice care.

We are one of nine HCFA-approved provider-sponsored Medicare Choices demonstration projects. We have just launched our new "MedCare Plus" point-of-service offering to deliver coordinated services to Medicare beneficiaries; our target is to enroll 4,000 seniors in the first year. In the first two weeks we have signed up 200 beneficiaries. We're proud of what we're now able to offer beneficiaries, including no additional premium -- meaning no need for them to buy a supplemental "Medigap" policy -- and only a modest copay and deductible to receive services out of our network. We reward healthy behavior -- for example, by giving extra benefits

for exercising regularly. We believe we can provide superior service by having roughly three times the number of service representatives compared to others in the field. And, from a clinical perspective, our own physicians oversee utilization management, not outside reviewers. On behalf of the American Hospital Association and its 5,000 hospitals, health systems, and other providers of care, I welcome this opportunity to testify on provider-sponsored organizations, or PSOs.

Toward a more integrated health care market

Marketplace and regulatory pressures are rapidly reshaping health care delivery into "integrated" systems of care. Provider-sponsored organizations -- such as Crozer-Keystone's MedCare Plus program -- are one emerging form of increased delivery system coordination. PSOs can help with the critical task of balancing health care resources with growing needs -- particularly important in caring for the elderly as the baby boomers begin to retire -- all within the context of a community and its overall health. Consequently, we are pleased to testify in support of PSOs and their potential value to the Medicare program. And, we commend Rep. Jim Greenwood (R-PA) for introducing -- along with Rep. Charles Stenholm (D-TX) -- H.R. 475, legislation we wholeheartedly endorse, that would add PSOs to the options available to Medicare beneficiaries.

Today, we would like to explain what PSOs are, and outline the critical elements embodied in H.R. 475 that we believe must be part of any Medicare PSO legislation.

PSOs come in many shapes. Integration among hospitals, physicians, and other caregivers is a prime characteristic of PSOs. The integration can take many forms, among them: consolidating administrative activities; jointly sharing payment risk; coordinating clinical care; and combining or merging corporate and governance structures. PSOs accomplish this integration through various organizational structures, and have the ability to accept financial risk-sharing for a broad spectrum of services in their contracts with health plans, including under capitated payment (a fixed, per-person, per-month payment). Consequently, PSOs can make a major contribution to the evolution in how managed care is practiced in this country. As community-based, integrated networks of providers that offer a spectrum of care in exchange for a fixed payment, PSOs can achieve both *cost* and *quality* goals:

- **PSOs achieve the cost efficiencies necessary to hold down health care costs** by **directly managing** both the **use** of services **and the cost of producing those services**. PSO direct contracting relationships have the potential to decrease the overall costs of health care by reducing one layer of billing and administrative processes injected by insurance companies and many HMOs. Such direct contracting preserves the largest percentage of health premiums or government health expenditures for direct patient care and community health improvement initiatives.

- **Since PSOs are provider-driven, not insurer-driven, they put clinical decisions in the hands of those most capable of balancing efficiency and patient care --** local community-based health care providers.

- **PSOs address consumer concerns about stable relationships with providers.** Under some commercial managed care plans, panels of participating clinicians change frequently as the plans move from one provider group to another, seeking deeper discounts. PSOs are built on a more stable provider base -- often the very providers with whom consumers already have established relationships. Consumers don't have to change plans to follow their providers; their providers *are* the plan.

- **PSOs are good for local communities**. Rooted in communities, PSOs are attentive to the long-term interests of the communities they serve. They are more likely, for example, to focus on improving the health of the entire community.

Essential Elements of a Medicare PSO Option

More important, PSOs can provide both cost savings and quality to Medicare beneficiaries as well. PSOs carry benefits beyond those normally associated with a managed care plan -- such as the ability to choose physicians and hospitals, not just a plan and whichever providers come with it. We're the hospitals and doctors our seniors know. Because PSOs help maintain the direct link between patients and providers that Medicare beneficiaries often cite as the most important aspect of their care (and also cite as a major reason for staying with traditional fee-for-service Medicare), we believe these benefits will motivate Medicare beneficiaries to choose PSOs.

But in order to assure that PSOs are a viable option for seniors, Medicare should enter into contracts only with PSOs that provide coordinated care, accept financial risk-sharing, and meet

Medicare's risk contracting requirements. While the basic definition of a PSO is a public or private provider or group of affiliated providers organized to deliver a spectrum of health care services under contract to purchasers of such services, **Medicare-qualified PSOs** should be even more precisely defined, as they are in H.R. 475. Important criteria, included in the bill, are as follows:

First, Medicare-qualified PSOs must provide the entire Medicare benefit package to seniors. In addition, they must deliver the *substantial portion* of those services -- significantly more than half -- directly through their own affiliated providers. Most of the remaining services must be delivered by providers who are under contract to the PSO. This allows health care providers to come together to form a delivery system through a variety of means, including common ownership, common control, or substantial shared financial risk. It also ensures sufficient integration to support true coordinated care and capitation.

Second, all Medicare health plan options should ensure that beneficiaries are protected from poor quality care, financial liability from poorly managed plans, and inappropriate plan behavior. To that end, H.R. 475 would require that all PSOs be subject to federal Medicare requirements imposed on Medicare risk contractors regarding marketing practices, enrollment processes, enrollee rights to review of coverage decisions, appeal mechanisms that involve external reviewers, and disclosure of plan information.

Third, H.R. 475 proposes to enhance quality assurance standards and make solvency standards more appropriate to PSOs. The revisions we support are, in many cases, applied only to PSOs, based on distinctive PSO characteristics; others apply to all Medicare risk contractors. These include the following:

- **Waive the 50/50 requirement in favor of direct measurement of quality and coordinated care experience.** The requirement that Medicare risk contractors have at least 50 percent commercial enrollment (the "50/50 rule") is a significant barrier to PSO Medicare contracting. It doesn't recognize the experience PSOs gain as they contract to provide patient care services to managed care organizations because of their "down stream" care giver position.

  Medicare-qualified PSOs would not enter the commercial market to sell health plan coverage. Rather, they would maintain their traditional direct relationships with Medicare by using their coordinated care experience gained under managed care contracts to provide coordinated care to beneficiaries under a Medicare health plan contract.

  As in H.R. 475, we believe all Medicare risk contractors, including PSOs, should be able to have the 50/50 rule waived *if* they meet enhanced quality assurance requirements and can demonstrate experience in providing coordinated care (as a health plan or, more likely, under contract with health plans). Waiver of the rule would acknowledge that its original

purpose as a proxy for quality measurement is no longer necessary, given today's improved quality measurement tools.

- **A federal certification process should be provided initially for PSOs, with involvement of state regulators appropriate to a Medicare-only plan.** It is inappropriate to initially require both federal certification *and* state licensure for PSOs when PSOs are directly enrolling only Medicare beneficiaries. Medicare already has its own rules on contractor capabilities and consumer protections, and the vast majority of these rules would apply to PSOs without change.

From a government efficiency perspective, it does not make sense to initially require state licensure. The state's findings are of little use to Medicare in judging whether PSOs meet federal requirements; Medicare must do its own evaluation, under its own rules, of the PSO. If the PSO is not directly enrolling individuals in the commercial market, a state licensure process is inappropriate and not needed on top of federal Medicare requirements.

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We support H.R. 475's reliance on an initial four-year period of federal rules and federal certification to enroll Medicare beneficiaries. During that time, Medicare could contract with state agencies to locally monitor on-going PSO performance. After the first four years, Medicare could then allow state licensure in those states where their requirements

are identical to the federal standards for solvency, and generally line up with federal requirements for quality.

- **Adopt a PSO solvency standard that is responsible and specific.** In the 1995-96 Congressional debate about how to include a PSO option, the Congressional proposals included a process for the Secretary to develop solvency standards, without the inclusion of any specific statutory requirements. Unfortunately, the lack of a specific standard created the inaccurate impression that hospitals and physicians did not support appropriate solvency requirements, and raised significant concerns.

  Let us assure you at the outset that the American Hospital Association supports a rigorous and specific standard, like the one included in H.R. 475. We, like you, do not want to encourage undercapitalized PSOs to contract with Medicare. Specifically, we recommend that the current Medicare HMO/CMP requirements for financial soundness, insolvency plans, provider contracting, and continuity of care and coverage be applied to PSOs as well. This ensures that both Medicare beneficiaries and the Medicare program will be equally protected under PSO contracts, as they are under HMO and CMP contracts.

  Further, we recommend that the PSO financial soundness test be specified in the Medicare law. We believe the financial soundness test should be based on the net worth and reserve requirements found in the National Association of Insurance Commissioners' (NAIC) current model HMO act.

Basing the federal standard on NAIC's model, as H.R. 475 specifies, does also require limited revisions to reflect accounting differences and payment variations between PSOs and HMOs, and to assure that the model act's recognition of health delivery assets in assessing net worth is maintained. This last issue is especially important to PSOs because it recognizes that their core business is the delivery of health care services -- not selling insurance. This recognition acknowledges that PSOs meet their coverage commitments primarily through using their assets to produce the covered services directly, rather than selling investment assets to pay claims. The presence of a claims reserve requirement ensures the PSO has the capacity to pay for services they do not produce directly, such as out-of-area services.

We also recommend that alternative means of demonstrating financial soundness be recognized, such as letters of credit, financial guarantees, reinsurance or stop loss insurance, certification by an independent actuary, unrestricted fund balances, diversity of lines of business, and presence of non-risk related revenue. These alternatives include items found in many, but not all, state statutes or regulations, and many of the alternatives are practices common within the insurance industry.

- **Medicare should take advantage of the unique capabilities of PSO health care delivery systems to consistently implement high-level quality requirements that reflect the state-of-the art in quality management and also address problems with some current forms of managed care.** There are many problems with some current

forms of managed care that health care providers see every day, such as the degree of intrusion in the doctor-patient relationship caused by health plan cost management techniques, the degree to which clinical management policies are not developed by practicing clinicians, and the degree to which cost considerations seem to override quality considerations. PSOs provide a way for hospitals and physicians to develop and implement their own approaches to addressing these problems.

PSOs would develop and implement plans to move from utilization review done on a case-by-case basis as part of a precertification or claims review process, to the evaluation of patterns of care as part of an integrated quality assurance and utilization management process. This will develop the mechanisms that are most effective in evaluating and altering inappropriate care patterns, while putting clinicians back in charge on a day-to-day, patient-by-patient basis.

- **PSOs participating in Medicare should be eligible for full-risk and partial-risk payments.**

  ✓ Currently, Medicare full-risk plans are paid on the basis of 95 percent of the Adjusted Average Per Capita Cost, or the AAPCC. That system itself, however, is seriously deficient in several ways and in need of reform.

There is wide variation in historic fee-for-service utilization patterns, and therefore a resulting wide variation in health plan payments -- *more than 300 percent among counties across the United States*. We believe these payments should be made more equitable across the United States in a way that will allow more communities to establish provider-sponsored networks.

We advocate Medicare managed care payments that are uniform across the country, but then adjusted to reflect differences in the cost of delivering care due to the fact that some areas may care for less-healthy, more costly Medicare beneficiaries. The current AAPCC should be blended with a new payment rate that eliminates differences in historical patterns of use across counties. And, a payment floor should be quickly established to raise payments in the lowest-rate areas.

Finally, we believe that payments for graduate medical education (GME) and for those hospitals treating a large volume of low-income individuals -- the disproportionate share hospitals (DSH) -- should be "carved out" from Medicare managed care payments. The carve out is needed because traditionally the Medicare program has paid hospitals directly for the special, additional costs associated with teaching and with treating large numbers of low-income individuals. Because these special payments remain buried within a fixed, Medicare health plan payment, health plan organizations receiving the payment are

not passing on the funding to those institutions actually incurring the added costs. Medicare payments for clinical education and for hospitals treating a disproportionately large share of low-income individuals should be paid directly to the organizations fulfilling those responsibilities.

✓ In addition to AAPCC payment changes, we support a "partial risk" payment option for all Medicare plans, including PSOs. Where Medicare and a plan agree to partial risk payment, the plan would be responsible for offering the full Medicare benefit package, but would be paid a mix of capitation and cost for all services. Under such arrangements, the Medicare program shifts much, but not all, of its risk to the plan. This creates a more viable option in communities that have little or no access to such managed care options now. This provision allows participation by smaller risk contractors such as those in rural areas who may not be able to absorb the wide swings in costs that often occur in smaller pools of beneficiaries. It would also enable the greater use of coordinated care for the disabled and chronically ill.

We believe partial risk payment is critically important to efforts to expand the availability of coordinated care options under Medicare. Partial risk methods, already in use in the private sector to a significant degree, would increase the tools available to modernize Medicare.

Conclusion

We commend Rep. Greenwood and Rep. Stenholm for advancing the debate on PSOs -- H.R. 475 includes the essential elements needed to create an important new option for Medicare beneficiaries. More importantly, their bill demonstrates that the concerns raised last year by Members and interest groups were heard and have resulted in legislative improvements and refinements.

Mr. Chairman, we appreciate this opportunity to share with you our views on provider-sponsored organizations. AHA and its members are focusing significant resources on moving health care delivery to a more efficient and effective integrated model. We believe PSOs are the right vehicle to accomplish this goal. Powerful market, regulatory, and demographic forces undergird our view. AHA and its members believe that extending provider-sponsored organizations to Medicare would bring benefits to beneficiaries, to providers, to communities, and, perhaps most significantly from this Committee's point of view, to the Medicare program itself.

The AHA is deeply concerned about the impending Medicare financing crisis. Action must be taken soon to make fundamental structural changes that will allow this nation to continue to meet the health care needs of the elderly. Broadening beneficiaries' choice of Medicare health plans, including PSOs, is a vital part of this effort. Repairing the AAPCC's present variability and unpredictability should be another.

Overall, the Medicare program has been an outstanding success in bringing health care security to the elderly. In a nation where eroding access to health care coverage in the working population is already contributing to a steady rise in the uninsured, we cannot afford a future in which we lack the resources to keep the Medicare promise. We look forward to working with you to make provider-sponsored organizations a significant factor in a fiscally healthy Medicare program.